MEDICAL EXAMINATION REPORT

For S or P Endorsement

MV3030B 6/2005 Ch. 343 Wis. Stats.

Incomplete forms will be returned for completion.

Clear Form

Wisconsin Department of Transportation
Medical Review
P O Box 7918
Madison, WI 53707-7918
Telephone: 608-266-2327; FAX: 608-267-0518
E-mail: dre.dmv@dot.state.wi.us

Applicant Name	Birth Date
Street Address	Operator License Number
City, State, ZIP Code	Area Code - Telephone Number

Pursuant to Trans 112, Wis. Admin. Rules (copy available upon request), this report is to be completed prior to consideration for licensing. This report will not be made available to the public without your written authorization naming the person(s) you designate to receive this information. Payment for the medical examination and preparation of the physician's report is your responsibility.

Section A HEALTH HISTORY: Applicant completes this section when applying for P and S endorsement.

YES NO	YES NO	YES NO
☐ ☐ Alcohol or other drug abuse or dependency within the past 12 months	☐ ☐ Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date _____	☐ ☐ Positive TB in a communicable form
☐ ☐ Alcohol or other drug abuse or dependency within the past 12 - 24 months Controlled by treatment ☐ Yes ☐ No	☐ ☐ Mental/Emotional Functions	☐ ☐ Missing or impaired hand, arm, foot, leg
☐ ☐ Blood pressure over 180/105	☐ ☐ Diabetes or elevated blood sugar controlled by ☐ Diet ☐ Pills ☐ Insulin	☐ ☐ Seizures, epilepsy Episode Date _____
☐ ☐ Heart disease or heart attack, stroke, other cardiovascular condition	☐ ☐ Kidney disease, dialysis	☐ ☐ Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
	☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis	☐ ☐ Loss of, or altered consciousness Date _____
	☐ ☐ Required oxygen use	☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring

For any YES answers, indicate onset date, diagnosis, and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

I certify that the answers and statements made on this report are true and correct. I authorize the examining physician to release full details of an examination upon request to my employer, the School Board and the Wisconsin Department of Transportation.

X _____
(Applicant Signature) (Date)

This report must be based on an examination conducted within the past 90 days.

Note to Examining Health Care Professional: This examination report is required of a person applying for a school bus endorsement. The applicant must present this completed form to the Department of Transportation. Any charges or fees are the responsibility of the applicant. The Secretary of the Department of Transportation is, by statute, responsible for the decision of driver's licensing. Your report will be advisory in determining eligibility. A copy of Trans. 112, Wis. Admin. Code, which details the medical standards for licensing, is available upon request.

Section B HEALTH HISTORY: Health Care Professional completes this section for applicant applying for S endorsement.

YES NO	YES NO	YES NO
☐ ☐ Alcohol or other drug abuse or dependency within the past 12 months	☐ ☐ Heart surgery (valve replacement/bypass, angioplasty, pacemaker, AICD) Date _____	☐ ☐ Positive TB in a communicable form
☐ ☐ Alcohol or other drug abuse or dependency within the past 12 - 24 months Controlled by treatment ☐ Yes ☐ No	☐ ☐ Mental/Emotional Functions	☐ ☐ Missing or impaired hand, arm, foot, leg
☐ ☐ Blood pressure over 180/105	☐ ☐ Diabetes or elevated blood sugar controlled by: ☐ Diet ☐ Pills ☐ Insulin	☐ ☐ Seizures, epilepsy Episode Date _____
☐ ☐ Heart disease or heart attack; stroke, other cardiovascular condition	☐ ☐ Kidney disease, dialysis	☐ ☐ Neuro/Muscular disease, e.g., ALS, MS, Head Trauma
	☐ ☐ Lung disease, emphysema, asthma, chronic bronchitis	☐ ☐ Loss of, or altered consciousness Date _____
	☐ ☐ Required oxygen use	☐ ☐ Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring
		☐ ☐ Inability to hear with or without hearing aid - instruction given in normal conversational tone.

For any YES answers, indicate onset date, diagnosis and any current limitations. List all medications (including over-the-counter medications) used regularly or recently.

Can the applicant recognize and distinguish amoung traffic control signals and devices showing standard red, green and amber colors? ☐ Yes ☐ No

Are corrective lenses required when driving? ☐ Yes ☐ No

Examining Authority Signature & Medical License No. (If different from below)

X

Numerical readings must be provided. **REQUIRED**

ACUITY	UNCORRECTED	CORRECTED	TEMPORAL FIELD OF VISION IN °
Right Eye	20/	20/	Right Eye
Left Eye	20/	20/	Left Eye

I certify that I have examined this applicant and that I am licensed to practice _____ (MD, DO, PA, DC, MSN, FNP, GNP, RN).

Print Name	Patient Examination Date: Month - Day - Year	
Authorized Signature	Medical License No.	Area Code-Office Telephone No.

X

Print